POR SF
11.3.31.1.1 827
V42 T 07393

Occupational Medical Center
1313 N.W. 19th Avenue
Portland, Oregon 97209
(503) 226-6744

FOR WCD USE ONLY

Insurer Claim No. | Emp. No. - FOR WCD ONLY | LOC.

WORKER

Time of Injury: ☐AM XX PM	Date of Injury: 9 / 20 / 84		1
Worker's Legal Name (First, Middle Initial, Last): WILLIAM B. ROCKWELL	Date of Birth: 8 / 13 / 34	Male ☒ Female ☐	Last Date Worked: / /	2
Worker's Address: 1709 S.W. Blankenship Rd.	City: West Linn	State: Oregon	Zip: 97068	Worker's Tel. No.: None	3
Social Security Number: 535 - 30 - 0895					4
Occupation: Laborer					5
Hospitalized as Inpatient? If yes, give hosp. name: ☐Yes ☐No					6
Employer's Telephone Number: 233-8221					7
Employer's Business Name (be specific): Port of Portland	Address: P.O. Box 3529	City: Portland, Oregon	State: 97208		8
Was Body Part Injured Before? If yes, describe: ☐Yes ☐No					9

INSURER

Fred S. James & Company of Oregon
111 S.W. Columbia
Portland, Oregon 97201

THE WORKERS' COMP. DEPT. ASKS YOU TO SEND THIS FORM PROMPTLY AND DIRECTLY TO THE INSURER PROPERLY ADDRESSED. IF ANY QUESTION, CALL TOLL-FREE NUMBER SHOWN AT THE RIGHT. THIS REPORT IS DELINQUENT IF HELD MORE THAN 72 HOURS.

WORKER'S STATEMENT OF CAUSE AND NATURE OF INJURY OR EXPOSURE
Hit pallet w/chemicles on it while driving a hyster at work. Got chemicles in right eye.

C&S DEPT→

Give name of your private health insurance company.

When signed this authorizes release of medical information and becomes NOTICE OF CLAIM.
Signature of Worker

10

If you do not know the name and address of the insurer, contact the employer. If the employer cannot be reached, call Workers' Compensation Department Toll Free and Ask for "EMPLOYER'S COVERAGE".
From Portland 229-5700 From Eugene 686-7500 From Salem 378-4954 Direct From All other areas 1-800-452-7813

PHYSICIAN

DESCRIBE COMPLAINTS
3 84 9:31

11

NATURE AND LOCATION OF INJURY OR EXPOSURE
No foreign body seen in right eye.

12

Is Condition Work Related? If "no", explain
☒ Yes ☐ No ☐ Undetermined

13

Released for Work? ☒ Yes ☐ No | IF YES, GIVE DATE: 9 / 20 / 84 | Check One: Regular ☒ Modified (Give Limitations) ☐

14

ER ATTENTION HOSP. EMERG. ROOM: (1) COMPLETE ABOVE SECTIONS (2) ATTACH "ER" REPORT (3) SEND TO INSURER.

X-Rays? If Yes, Give Findings.
☐ Yes ☒ No

15

USEPA SF
1286699

DIAGNOSIS
No chemical tissue damage to right eye from chemicals.

16

FIRST TREATMENT
Time of Day: 1:30 ☐AM ☒PM | Date: 9 / 20 / 84
Type of Treatment: Take ASA or tylenol for pain. Eye washed for 10 minutes. PERRL anterior chamber clear. Flourescein negative.

17

Date of Next Treatment: As necessary | Estimate Length of Further Treatment: ___ Months and/or 0 Weeks | Medically Stationary? ☑ Yes ☐ No | Will Injury Cause Permanent Impairment? ☐ Yes ☐ Undetermined ☑ No

18

If Case Referred to another Doctor, Give Name and Address:

19

REMARKS: NO ASSIGNMENTS TO WORK REQUIRING

Lifting in Excess of:	☐ Climbing	☐ Prolonged Walking	☐ Pushing, Pulling, Carrying	☐ Accurate Vision
☐ 0-10 Lbs.	☐ Repetitive Bending	☐ Dangerous Machinery Exposure	☐ Reaching Above Shoulders	☐ Ability to Hear
☐ 10-20 Lbs.	☐ Kneeling	☐ Above Ground Level	☐ Any other than Desk or Bench Work	☐ Pulmonary Irritants
☐ 20-50 Lbs.	☐ Prolonged Standing	☐ Mobile Equipment Operations	☐ Use of ___ Hand	☐ Skin Irritants
☐ 50-100 Lbs.	☐ Prolonged Sitting			☐ Other ___

20

Type Name of Physician and Degree: John S. Endicott, MD	Address: 1313 N.W. 19th, Portland	Telephone Number: 226-6744	21
Medical Aid Account Number	Date: 9 20 84	Doctor's Signature: John S. Endicott MD	22

EMPLOYER'S COPY

436-827 (8-79) STATE OF OREGON • Worker's Compensation Department • Labor and Industries Building • Salem, OR 97310

POPT1S800014